

OFFICIAL FILE COPY

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 03 - 07	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: August 1, 2003	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(26) and 1934		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2003 \$ 19,109.13 b. FFY 2004 \$ 114,655.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT	
10. SUBJECT OF AMENDMENT: Amendment 642 adds the Program of All-Inclusive Care for the Elderly (PACE) as a Medicaid State Plan option.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Sent to Governor's Office this date. Comments, if any, will <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL be forwarded upon receipt.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Jason Cooke</i>		16. RETURN TO: Jason Cooke State Medicaid/CHIP Director Post Office Box 13247 Austin, Texas 78711	
13. TYPED NAME: Jason Cooke			
14. TITLE: State Medicaid/CHIP Director			
15. DATE SUBMITTED: March 28, 2003			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 MARCH 2003		18. DATE APPROVED: 6 JUN 2003	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 AUG 2003		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Andrew A. Fredrickson</i>	
21. TYPED NAME: ANDREW A. FREDRICKSON		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH	
23. REMARKS: * Pen + Ink Change to Attachment * Fiscal Impact Fy 03 (\$4,786.93) Fy 04 (\$113,790.91)			

MAR 28 2003

Attachment to HCFA-179 for
Transmittal No. 03-07, Amendment 642

Number of the
Plan Section or Attachment

Basic Plan
Page 19c
Page 19d

Attachment 3.1-A
Page 11

Attachment 3.1-B
Page ~~11~~
10

Supplement 3 to Attachment 3.1-A
Page 1 – 6b

Number of the Superseded
Plan Section or Attachment

Basic Plan
New
New

Attachment 3.1-A
New

Attachment 3.1-B
New

Supplement 3 to Attachment 3.1-A
New

* Pen + Ink Change Per State

Revision:

November 2000

State/Territory: TexasCitation3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)1905(a)(26)
and 1934X Programs of All-Inclusive Care for the Elderly (PACE) services,
as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

STATE	<u>Texas</u>	A
DATE REC'D	<u>3-28-03</u>	
DATE APPV'D	<u>6-6-03</u>	
DATE EFF	<u>8-1-03</u>	
HCFA 179	<u>03-07</u>	

TN No. 03-07

Supersedes

Approval Date

6-6-03Effective Date 8-1-03TN No. SUPERSEDES: NONE - NEW PAGE

Revision:

November 2000

State/Territory: TexasCitation3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy
(Continued)1905(a)(26)
and 1934N/A Programs of All-Inclusive Care for the Elderly (PACE)
services, as described and limited in Supplement 3 to
Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

STATE	<u>Texas</u>	A
DATE REC'D	<u>3-28-03</u>	
DATE APP'D	<u>6-6-03</u>	
DATE EFF	<u>8-1-03</u>	
HCFA 179	<u>03-07</u>	

TN No. 03-01

Supersedes

Approval Date 6-6-03Effective Date 8-1-03TN No. SUPERSEDES: NONE - NEW PAGE

Revision:

November 2000

State/Territory: TexasAMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDICAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE	<u>Texas</u>
DATE REC'D	<u>3-28-03</u>
DATE APPE'D	<u>6-6-03</u>
DATE EFF	<u>8-1-03</u>
HCFA 179	<u>03-07</u>

A

TN No. 03-07

Supersedes

Approval Date 6-6-03Effective Date 8-1-03TN No. SUPERSEDES: NONE - NEW PAGE

Revision:

November 2000

State/Territory: TexasAMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE PROVIDED TO MEDICALLY NEEDY~~26~~
27.

Programs of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE	<u>Texas</u>
DATE REC'D	<u>3-28-03</u>
DATE APP'D	<u>6-6-03</u>
DATE EFF	<u>8-1-03</u>
HOFA 179	<u>03-07</u>

A

TN No. 03-07

Supersedes

Approval Date 6-6-03Effective Date 8-1-03TN No. SUPERSEDES: NONE - NEW PAGE

Revision:
November 2000

State/Territory: Texas

Name and address of State Administering Agency, if different from the State Medicaid Agency.

Texas Department of Human Services
701 West 51st Street; Austin, Texas 78751

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

42 CFR 435.120 & 42 CFR 435.236 - Institution

B. The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

TN No. 03-01

Supersedes SUPERSEDES: NONE - NEW PAGE

Approval Date 6-6-03

Effective Date 8-1-03

November 2000

TN No. SUPERSEDES: NONE - NEW PAGE

Revision:
November 2000

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. _____ The amount is determined using the following formula:

6. _____ Other
7. ☒ Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. N/A 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:	
(A) Individual (check one)	
1. _____ The following standard included under the State plan (check one):	
(a) _____ SSI	
(b) _____ Medically Needy	
(c) _____ The special income level for the institutionalized	
(d) _____ Percent of the Federal Poverty Level: _____ %	
(e) _____ Other (specify): _____	
2. _____ The following dollar amount: \$ _____	
Note: If this amount changes, this item will be revised.	
3. _____ The following formula is used to determine the needs allowance:	
_____ _____	

State: Texas
DATE ISSUED: 3-28-03
DATE APPROVED: 6-6-03
DATE EFF: 8-1-03
APPROVAL: 03-07

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

TN No. 03-07

Supersedes

TN No. _____

Approval Date

6-6-03

Effective Date

8-1-03

SUPERSEDES: NONE - NEW PAGE

Revision:
November 2000

STATE	Texas
DATE REC'D	3-28-03
DATE APPRO'D	6-6-03
DATE EFF	8-1-03
HQ/TA 179	03-07

(B) Spouse only (check one):

1. ☐ The following standard under 42 CFR 435.121:
2. ☐ The Medically needy income standard
3. ☐ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. ☐ The amount is determined using the following formula:

6. ☐ Not applicable (N/A)

(C) Family (check one):

1. ☐ AFDC need standard
2. ☐ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ☐ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. ☐ The amount is determined using the following formula:

6. ☐ Other
7. ☐ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. ☒ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a

TN No. 03-07

Supersedes

Approval Date 6-6-03

Effective Date 8-1-03

TN No. SUPERSEDES: NONE - NEW PAGE

Revision:
November 2000

community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

(A) ☐ The following standard included under the State plan (check one):

- (1) ☐ SSI
- (2) ☐ Medically Needy
- (3) ☐ The special income level for the institutionalized
- (4) ☐ Percent of the Federal Poverty Level: _____%
- (5) ☐ Other (specify): _____

(B) ☐ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

(C) ☒ The following formula is used to determine the needs allowance:

Community residence - individual needs allowance is the special income level for the institutionalized. For individuals requiring nursing facility care for more than three months, the personal needs allowance is the needs allowance for institutional residents (ref. State Plan 2.6A, Page 4A).

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

A	
STATE	Texas
DATE	3-28-03
DATE	6-6-03
DATE	8-1-03
DATE	03-07

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than that cost to the agency of providing those same fee-for-service State Plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See attachment ___ to Supplement 3 of Attachment 3.1A.

1. ☒ Rates are set at a percent of fee-for-service costs

TN No. 03-07

Supersedes

TN No. _____

Approval Date

6-6-03

Effective Date

8-1-03

SUPERSEDES: NONE - NEW PAGE

Revision:
November 2000

2. _____ Experience-based (contractors/State's cost experience or encounter date)
(please describe).
3. _____ Adjusted community rate (please describe)
4. _____ Other (please describe)

B. The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

No actuary was used.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE	<u>Texas</u>	A
DATE REC'D	<u>3-28-03</u>	
DATE APP'D	<u>6-6-03</u>	
DATE EFF	<u>8-1-03</u>	
HCFA 179	<u>03-07</u>	

TN No. 03-01

Supersedes

Approval Date 6-6-03

Effective Date 8-1-03

TN No. SUPERSEDES: NONE - NEW PAGE

IV. Reimbursement Methodology for Programs for All-Inclusive Care for the Elderly (PACE)

- (a) General specifications. The Texas Health and Human Services Commission (HHSC) determines the upper payment limits and the reimbursement rates for each PACE contractor.
- (b) Frequency of reimbursement determination. The upper payment limits and reimbursement rates are determined coincident with the state's biennium.
- (c) Upper payment limit determination. There are two upper payment limits calculated for each PACE contract: one for clients eligible only for Medicaid services and one for clients eligible for both Medicare and Medicaid services. An average monthly historical cost per client receiving nursing facility and/or Community Based Alternatives (CBA) services under the fee-for-service payment system is calculated for the counties served by each PACE contract for each type of upper payment limit.
 - (1) The upper payment limits for the biennium are calculated for the base period using historical fee-for-service claims data and member-month data from the most recent state fiscal year of complete claims available prior to the state's biennium.
 - (2) The historical costs are derived from fee-for-service claims data for clients receiving nursing facility services or CBA services in the counties served by each PACE contract meeting the following criteria:
 - (i) age 55 and older;
 - (ii) with Medicare coverage and without Medicare coverage; and
 - (iii) not receiving services under the STAR+PLUS managed care program.
 - (3) The historical costs include:
 - (i) acute care services, including inpatient, outpatient, professional and other acute care services;
 - (ii) prescriptions;
 - (iii) medical transportation;
 - (iv) nursing facility services;
 - (v) hospice services;
 - (vi) long-term care specialized services, such as physical therapy, occupational therapy, and speech therapy;
 - (vii) CBA services;
 - (viii) Primary Home Care (including Family Care) services; and
 - (ix) Day Activity and Health Services.

STATE	<u>Texas</u>
DATE REC'D	<u>3-28-03</u>
DATE APP'D	<u>6-6-03</u>
DATE EFF	<u>8-1-03</u>
HCFA 179	<u>03-07</u>

A

TN No. 03-07

Supersedes

Approval Date 6-6-03

Effective Date 8-1-03

TN No. SUPERSEDES: NONE - NEW PAGE

- (4) To determine an average monthly historical cost for the counties served by each PACE contract, the total historical fee-for-service claims data for the counties served by each PACE contract are divided by the number of member months for the counties served by each PACE contract.
- (5) To the average monthly historical cost per client is added a per member month amount for:
- (i) processing claims based on the state's cost to process claims under the fee-for-service payment system; and
 - (ii) case management based on the state's cost to provide case management under the fee-for service payment system for CBA clients.
- (6) The sum of the average monthly historical cost per client for each PACE contract and the amounts from (5) above are projected from the claims data base period identified in (c)(1) to the rate period to account for anticipated changes in costs for each PACE contract. The methodology used for trending historical costs for calculating PACE UPLs and rates is comparable to that used for trending fee-for-service costs.
- (D) Payment rate determination. There are two reimbursement rates calculated for each PACE contract: one for clients eligible only for Medicaid services and one for clients eligible for both Medicare and Medicaid services. The payment rates for each PACE contract is determined by multiplying the upper payment limits calculated for each PACE contract by 0.95.

STATE	<u>Texas</u>	A
DATE REC'D	<u>3-28-03</u>	
DATE APPRO'D	<u>6-6-03</u>	
DATE EFF	<u>8-1-03</u>	
HCFA 179	<u>03-07</u>	

TN No.: 03-07

Supersedes TN No.: New Material

SUPERSEDES. NONE - NEW PAGE

Approval Date 6-6-03

Effective Date 8-1-03